April 17, 2001

TO: Director

FROM: Senior Operations Research Analyst

SUBJECT: Distribution of fiscal year (FY) 2001 Indian Health Care Improvement Fund--ACTION

ISSUE

The Congress appropriated $30 million in FY 2001 for the Indian Health Care Improvement Fund (IHCIF). To this amount is added $10 million that was distributed non-recurring in FY 2000. This memo recommends for your approval a methodology for distributing the $40 million total for FY 2001.

DISCUSSION

In your August 28, 2000 letter to tribal leaders, you stated that "I have decided to distribute the $10 million IHCIF on an interim basis while continuing consultation to finalize a permanent methodology to apply in FY 2001 and afterwards." You asked the Level of Need Funded (LNF) Workgroup to continue working to finalize a methodology that considers the views of tribes and Indian health leaders.

Since August 28, 2000, the IHS together with the LNF Workgroup has conducted extensive additional tribal consultation including three regional forums and a national forum. Many tribal and Indian health care leaders attended the consultation forums and proposed a variety of modifications and refinements to the allocation methodology. The LNF Workgroup met to review the tribal input and to adopt modifications and refinements to the methodology accordingly. The LNF Workgroup sent a letter to you on February 13, 2001 containing its recommendations for refining the methodology for the FY 2001 IHCIF distribution.

Attachment A shows the proposed FY 2001 IHCIF distributions based on the recommendations below. Attachment B shows a series of charts that illustrate the numerical results. Please indicate your support for the recommendations by initialing on the "Approved" line.

RECOMMENDATION 1

I am conveying the request of the LNF Workgroup that you accept the allocation methodology recommendations contained in the February 13, 2001 letter (attachment C) from the LNF Workgroup ***except as modified by subsequent recommendations below.***

APPROVED APPROVED DISAPPROVED_____ Date_____

RECOMMENDATION 2

Given the

- evidence of links between underlying poverty conditions, lack of access, and poor health status, and
- consistent with strong expressions by many tribal leaders to put low health status, poverty, and lack of economic opportunity in the forefront of federal policy making for Indian country,

therefore, reinstate a poverty measure in the health status section of the allocation methodology. Combine the poverty index with the health status index recommended by the Workgroup by weighting the poverty index at 1/3 and the health status index at 2/3. The poverty index shall include the extent that poverty among American Indians and Alaska Natives (AI/AN) exceeds the rate of US All Races (a measure available only for IHS areas) and a measure of the prevailing poverty rate in counties served by each operating unit.

APPROVED APPROVED DISAPPROVED_____ DATE_____

RECOMMENDATION 3

Given evidence that a limited number of operating units that do not provide billable health care services cannot obtain collections for patients eligible for Medicare, Medicaid or private insurance coverage,

therefore, discount the flat rate estimate for other resources in the methodology from $797 per user to $399 per user for operating units that are more than 85% reliant on Contract Health Services. The discount is not 100% because these operating units still benefit from cost avoidance when their Medicare, Medicaid and private insurance eligible patients obtain care elsewhere.

APPROVED APPROVED DISAPPROVED_____ DATE_____

RECOMMENDATION 4

Given that

- $40 million available in FY 2001 is far short of the $1.7 billion deficiency compared to costs of equivalent services defined in the benchmark Federal Employees Health Benefit Plan (FEHBP) and
- priorities for allocating the limited available funds must be identified and
- section 1621(a)4 of the Indian Health Care Improvement Act requires the Indian Health Service (IHS) to address deficiencies for "…those Indian tribes with the highest levels of health status and resource deficiencies",

therefore, distribute FY 2001 IHCIF funds to operating units currently funded at less than 60 percent. Because $40 million is insufficient to eliminate resource deficiencies at the 60 percent level, distribute FY 2001 IHCIF funds in proportion to the deficiency of each qualifying operating unit, e.g., more funds to operating units with lower percentages.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 5

Consistent with support expressed during consultation forums to help operating units with the most extreme resource deficiencies,

therefore, distribute the FY 2001 IHCIF in a manner to insure that every operating unit is funded at no less than 30 percent as measured by the methodology in FY 2001.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 6

Because

- the national application of the allocation methodology may incompletely account for certain complexities and variations in and among local level operating units, and
- section 1621(b)2a of the Indian Health Care Improvement Act requires that "…funds allocated to each service unit… shall be used to reduce the health status and resource deficiency of ***each tribe*** served by such service unit",

therefore, the Area Office, after consulting with affected parties, may distribute IHCIF operating unit funds among the constituent parts of operating units based on actual service usage patterns or similar equitable measures.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 7

Given the

- refinement in the allocation methodology produced by extending consultation since August 28, 2000 and
- consistent with many proposals for maintaining stable funding for critically needed health services,

therefore, the FY 2001 IHCIF distribution to operating units shall be ***recurring*** to the operating units in years thereafter.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 8

Given that

- the current methodology defines an actuarial cost benchmark for assuring personal health care benefits to IHS users that is equivalent to the Federal Employees Health Benefits Plan (FEHBP) and
- critical "wrap around" IHS services such as clean water supply, safe waste disposal, public health activities, and community based health programs are not covered in the FEHBP and
- the term "Level of Need Funded" is regularly misunderstood to mean all needed and necessary funds, and
- the percentage cited in the current methodology for any operating unit is not a percentage of its true funding needs, but rather a percentage equivalence with the FEHBP,

therefore, change the name of the methodology from LNF to:

Option 1: **FEI** – **F**EHBP **E**quivalence **I**ndex. ____
Option 2: **FPI** - **F**EHBP **P**arity **I**ndex. ____
Option 3: **FDI** - **F**EHBP **D**isparity **I**ndex. APPROVED

APPROVED___APPROVED__ DISAPPROVED_____ DATE_____

Cliff Wiggins

Attachments